Senior Citizens' Secretariat
Newsletter

VOLUME 96 DECEMBER 2000

120 Ideas from The Federation

We've often heard politicians asking individuals and organizations for their ideas on making the country a better place for its citizens.

A great idea, says the Canadian Federation of Senior Citizens and Pensioners. They've got 120 to give to the Federal Government early in the new year.

That number, says Curtis DeCoste, of Boylston, NS and the new National President of the Federation, represents the number of resolutions passed at the Senior's Annual Meeting held a few weeks ago in Sydney. The resolutions, now being edited and catalogued, will be presented to the appropriate departments of the Federal Government, and to the Leader of the Opposition as well—sort of a memory-jogging device to help government remember what is being asked.

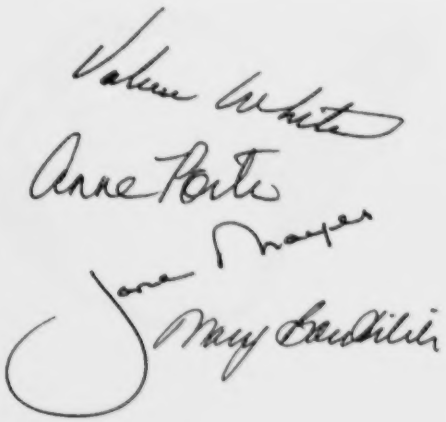
Curtis told us in a telephone conversation the other day that the resolutions range across a broad spectrum, from health, housing and highway betterment, to pensions, patent medicines and parental-grandparental issues revolving around visiting rights with the children.

Some of the resolutions have been on the plate before, but they bear repeating, say the seniors, who discussed and debated them at the Sydney convention.

Among the matters the seniors want to put before government:

Health care, the closing of hospital beds, the shortage of doctors and nurses, a review of Bill C-91 which provides patent protection for drug manufacturers against others who can produce similar medication at lower prices; long term homecare and a careful look at the rising cost of health services and drugs.

Merry Christmas from the staff of the Senior Citizens' Secretariat



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And then there's the high cost of transportation for seniors (especially in rural areas); the rising cost of fuel for travel and heating; the urgency about road conditions, including the need for twinning dangerous sections; higher pensions for seniors; repeal of the clawback provision which reduces a pensioner's benefits if he/she earns more that a prescribed amount of income.

The resolutions also want freedom from income tax on the death benefits paid a surviving spouse from the Canada Pension Plan; clear rules for grandparents to have visiting rights with their grandchildren in the wake of family disputes and breakups; retention of the Canadian Broadcasting Corporation's role as the national broadcasting service; and abandonment of the Federal consideration to privatize Ste. Anne de Belliveau Veterans Hospital in Quebec, fearing that it could lead to a lessening of veterans' care across the country.

"We plan to take our resolutions to each department concerned so that our concerns are made known to the appropriate ministers and senior staff. We hope to meet with the policy-makers early in the new year," said Mr. DeCoste.

The Guysborough County resident brings much experience and organizational savvy to his new job as Federation President. He and his wife Helen have been involved in the senior movement for many years and have held important leadership and advocacy roles.

It's fitting, too, that with the closeness that exists between veterans and seniors groups, Mr. DeCoste brings Royal Canadian Legion experience into play. He is currently president of the Guysborough Branch of the Legion.

Submitted by: Harold Shea

Secretariat Newsletter

The Secretariat Newsletter is published four times a year by the Senior Citizens' Secretariat and distributed free of charge. We welcome letters, articles and items of interest from you. Please include your name, address and telephone number on all correspondence.

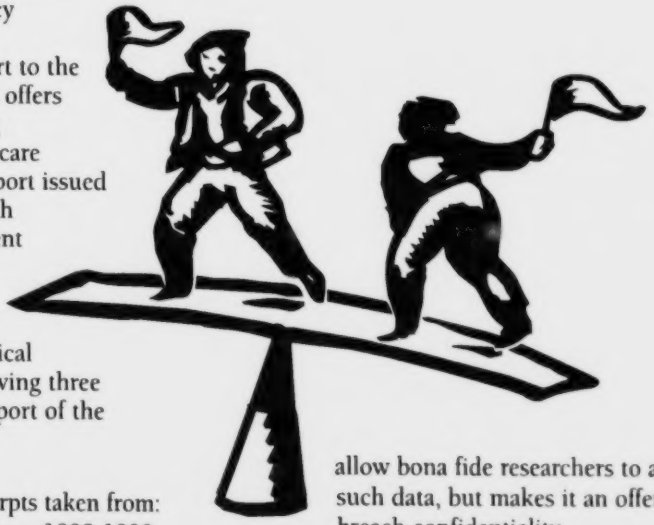
The Senior Citizens' Secretariat was established in 1980 to facilitate the planning and development of services and programs for seniors by coordinating plans, policies and programs presented by the departments of the provincial government. The Secretariat serves as a one door entry to government for seniors, seniors' groups and other provincial bodies concerned with aging issues. The Secretariat develops plans, policies and programs in partnership with other levels of government and agencies responsible for seniors.

The Secretariat's office is located at 1740 Granville Street, 4th floor, P.O. Box 2065, Halifax, NS B3J 2Z1. Tel (902) 424-0065; fax (902) 424-0561; toll-free 1-800-670-0065.

Can the Need for Privacy and the Need for Health Information be Balanced?

by Nancy Newall

Health Canada's plan to create a national health data network to help in health planning is sparking debate about patients' rights to privacy. Although Canada's Privacy Commissioner, Bruce Phillips, acknowledged in his annual report to the House of Commons that the plan offers "exciting prospects for improving Canadians' health and the health care system," he criticized the final report issued by the Advisory Council on Health Infostructure on the basis of patient privacy risks. For another perspective on this issue, we asked Dr. Eike-Kluge, UVic philosophy professor and biomedical ethicist, to comment on the following three criticisms made in the Annual Report of the Privacy Commissioner.



Criticism 1 (all criticisms are excerpts taken from: Annual Report Privacy Commissioner 1998-1999, The Health Infoway: Path to Health Surveillance ? http://www.privcom.gc.ca/02_04_07_e.htm) The final report issued by the Advisory Council on Health Infostructure fails "to acknowledge the patient's right to choose not to participate in any health information network. Nor does it speak about limiting surveillance of individual patients who do participate."

Dr. Kluge's Comments: This sounds acceptable however, what should be borne in mind is if a patient is a recipient of health care services, then the patient has a prima facie duty to participate in research that makes the delivery of such health care possible. Ethically, if the planners have a duty to provide health care, then they have a right to the means demonstrably necessary to provide that care. Data access is implicated here. What is ethically appropriate is not that the patient may withdraw from the data pool, but that the personal identifiers of the patients be deleted. Alternative to that—where it may not be possible to do this—is to follow the various provincial legislations that allow bona fide researchers to access such data, but makes it an offense to breach confidentiality.

Criticism 2 "The [final] report's recognition that groups of people can be stigmatized by having health information used against them was another important milestone. Unfortunately the recognition was limited to Aboriginal and immigrant communities. Any group of individuals can be perceived as having particular attributes that are then ascribed—rightly or wrongly—to any member of the group. The conclusion can be simplistic and dangerous. The concept of "group" privacy deserves broader interpretation in the health care context and more attention overall."

Dr. Kluge's Comments: This is fair comment. No particular group has a greater right to privacy and confidentiality than any other group.

Criticism 3 "Fuelling our concern is that tone of the companion Health Information Roadmap, produced by Health Canada, Statistics Canada and the Canadian Institute for Health Information. The roadmap describes the steps needed to build a comprehensive health information system and infrastructure to deliver health care to individuals. While it acknowledges that "individuals have important rights over when and how their personal information is used," its answer to protecting those rights is patient access to privacy policies, and stripping names from the medical information. The first risks being mere window dressing; the second attempts to provide confidentiality, not privacy. Protecting patient"privacy"by replacing patients' names with identifying numbers is a simplistic solution to a complex problem. It is a simple matter to re-identify the individuals and so unlock a comprehensive and intensely detailed profile."

Dr. Kluge's Comments: This is unfair and untrue. Privacy can be guaranteed if the list linking identifiers and names is kept physically separate from the master documents and can be accessed only by duly authorised individuals for duly approved purposes. Not only that: this comment ignores the fact that there are certain circumstances where one would want to be able to trace the source of information so as to help the individuals. For instance, if a screening programme found out that certain conditions are indicative of a hither to unidentified serious problem, one wants to be able to trace. The Red Cross Blood Programme was unable to do that with the hepatitis infection data. We should have learned from this not that one does **not** want to be able to link, but that one **does** want to be able to link under certain circumstances. The above comment, therefore, strikes me as not only simplistic in itself, but to ignore completely the ethics of due care.

Source: Centre on Aging: Research throughout the Life Course, Victoria, BC

Shooting from the Hip

Golfers know him as "Nick the Wedge" because of his prowess with the club. But it would also be reasonable to call him "Nick the Hip". Four-time Canadian Amateur champion Nick Weslock, now 82, has undergone five hip replacements and continues to play excellent golf. Anybody looking to a "poster senior" for this operation need look no further.

"I've had three on my left and two on my right," says Weslock, who has played in four Masters. "The reason I've had to go back is that the rotation in my swing loosened the stem in the femur. But every operation has left me pain-free and has allowed me to keep on playing golf."

Weslock had his first hip replacement in 1973, with the most recent in 1999. While it's unusual for an individual to have so many, Weslock has never been leery of the procedure. It's all about quality of life, he says, and the hip replacements have never slowed him down—in fact, Weslock still competes and regularly shoots in the mid-70s.

"I average 240 yards off the tee," he says, "and I think that's pretty good. I try to let the golf club swing me, rather than forcing myself to swing it."

The eight-time Ontario Amateur and seven-time Ontario Open champion is hardly the only high-profile golfer to have found new life in golf via hip replacement surgery. None other than Jack Nicklaus, 60, had the procedure two years ago, and has returned to play some fine, high-level golf—in April, he made the halfway cut at the Masters, and this season he's also playing the U.S. and British Opens, plus the PGA Championship. Nicklaus knows he wouldn't be golfing at all without having had hip replacement surgery.

Then there are the thousands and thousands of recreational golfers who have enjoyed the game following the operation. Ernie Skrow, a 67-year old Torontonian, is one.

Skrow had his surgery nine years ago, six years after first experiencing hip-related pain. While stretching and strengthening exercises initially helped him minimize the discomfort—he also sought physiotherapy and chiropractic help—he eventually required hip replacement surgery.

"It got to the point where I couldn't get out of the car," he recalls. "There were times I couldn't put one foot in front of the other. The funny thing was my back, my leg and my ankle hurt me—but never the hip. But it was the hip that was causing my problems. The pain went away the day after the surgery, and after rehab I was back on the course."

It was Dr. Marvin Tile, a consultant orthopaedic surgeon at the Sunnybrook and Women's College Health Sciences Centre in Toronto and a professor of surgery at the University of Toronto, who performed Skrow's operation. An active golfer himself, Tile has countless examples of how replacement surgery—its formal name is total hip arthroplasty—has helped golfers continue playing.

"The main indication that surgery is required is a seriously arthritic hip," Tile says. "The pain from arthritis is what leads to surgery. I always ask a patient, 'Are you having fun in life? Is the pain taking over?' If it is, and an x-ray shows the hip is the problem, it could be time for the surgery."

While hip replacement surgery can certainly improve an individual's quality of life, it does have its limitations.

"I had one man in his late 80s who was told he could walk 18 holes but not 36, so he wanted a hip replacement," Tile says. "I thought that was unrealistic. On the other hand, it's wonderful to help people regain enjoyment of the game."

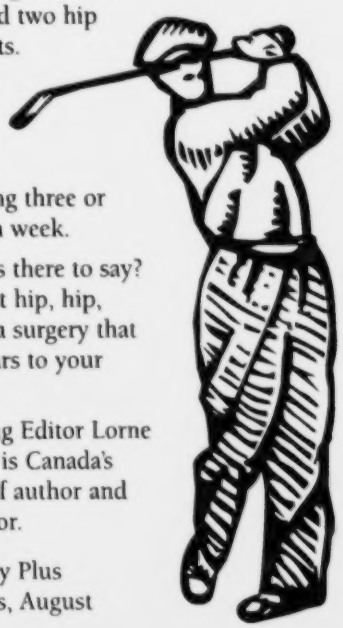
What of the "post-op" effects on one's golf game? As Nick Weslock was quick to learn, it's crucial that golfers returning to the course know just how far they can push themselves. Having had his most recent hip replacement only last November, Weslock found he needed to restrict his lower-body motion during his swing. Gradually, as he let the club swing him, Weslock noticed his body was following. He was gaining mobility in his lower body and finishing with all his weight on his front foot, just as the experts advise.

"The only pain I have now is from a bad shot, not hip pain," Weslock says. "Hip replacement surgery is really marvelous. Just to walk out free from pain is wonderful. And then to get back on the course and play decently, well, that's a big bonus."

It's a bonus available to all golfers who have suffered hip problems and for whom hip replacement surgery is an option. As Dr. Tile emphasizes, there's nothing in the golf swing per se that should cause hop problems. He points out that sports such as tennis (especially singles tennis) squash and handball, with their frequent stops and starts, are far more likely to lead to hip problems.

"Once you get structural changes in the hip and you're in pain it's time to think about surgery," Tile counsels. "You can't reverse arthritis once those changes happen and the hip reaches a certain

Golfers need not worry, however. They can look to Nicklaus, Weslock, and Senior PGA Tour winner George Archer, who has had two hip replacements. And Skrow is out on the course, again playing three or four times a week.



What else is there to say? Nothing but hip, hip, hooray for a surgery that can add years to your golfing life.

Contributing Editor Lorne Rubenstein is Canada's premier golf author and commentator.

Source: Fifty Plus CARP News, August 2000

Book Reviews

Examining Hand Problems and Injuries

The Hand: Primary Care of Common Problems and *The Hand: Examination and Diagnosis* are informative guides for the evaluation and treatment of common hand injuries, diseases and dysfunction.

The Hand: Primary Care of Common Problems is a concise manual for surgeons, family physicians, physical therapists, medical students and nurses. The companion volume, *The Hand: Examination and Diagnosis*, focuses on procedures that can be performed in the medical practice. Both books demonstrates therapeutic techniques that can lead to satisfactory recovery and successful subsequent care.

Both books are available from the American Society for Surgery of the Hand.

For more information, call: 1-847-384-8300.

Empowering Adults With Disabilities

Individuals with developmental disabilities are confronted with a new reality. *A Textured Life;. Empowerment and Adults with Developmental Disabilities* explores that new reality, focusing on the adults and their experiences.

The authors have conducted one of the most extensive surveys of Canadian support services available for adults with developmental disabilities. Every province and territory contributed information on services, including how they are funded. The authors also visited five different regions where they conducted 141 in-depth interviews with the targeted adults, their families and support staff.

A Textured Life will benefit all those concerned with helping individuals establish textured lives. The book is available from Wilfrid Laurier University Press. Contact (519) 884-0710 ext. 6124.

A Passionate Look at Canadian Nursing

In *Critical Care: Canadian Nurses Speak for Change*, journalist Andre Picard takes readers to the front lines of a profession that is undergoing dramatic changes. Picard examines the many facets of nursing through birth, childhood, and adolescence to maturity, old age and end-of-life care. He explores nursing from hospitals, mental health facilities and research laboratories to patients' homes and even overseas in war zones. *Critical Care* includes in-depth profiles of more than 40 nurses involved in various aspects of daily care.

The book includes Picard's commentary on the challenges of nursing today and recommendations for meaningful and efficient change. *Critical Care* is aimed at nurses and health professionals as well as Canadians who receive their care. *Critical Care* is published by Harper Collins Canada Ltd.

For more information, call (416) 975-9334.

A Self-Training Guide for Volunteers

Being a volunteer requires skill, sensitivity, perseverance, a specialized knowledge base, personal integrity, sincerity and endurance.

Based on a proven program for training volunteers, *Training Volunteers for Community Service* is a personal journal and hands-on workbook for developing the skills people need to become an effective volunteer for a service organization. A companion to the *Training Volunteers for Community Service* manual, this workbook contains information about sixteen modules found in the Shanti Volunteer Training Program (Shanti is a San Francisco-based organization that provides service to persons with HIV-AIDS).

Training Volunteers for Community Service is available from Jossey-Bass. To order, call 1-888- 378-2537.

Innovative Geriatric Homecare Service

Social Work for Geriatric Home Health Care: The Blending of Traditional Practice with Cooperative Strategies focuses on the case management of geriatric individuals.

The book provides the reader with organized and cooperative methods of providing home health care for the elderly and presents improved methods for managing geriatric cases to give clients optimum care. Readers interested in the future of home care will also find material of value within its pages.

Social Work for Geriatric Home Health Care: The Blending of Traditional Practice with Cooperative Strategies was written by Lucille Rosengarten and is available from The Haworth Press at 1-800-HAWORTH.

Customer Service and Health Delivery

Customer Service in Health Care: A Grassroots Approach to Creating a Culture of Service Excellence by Kristin Baird emphasizes action, as opposed to theory to improve customer service levels.

According to the author, the day-to-day challenges of creating a thoroughly customer-oriented culture in a health care organization can be met "if leadership appreciates the key role of middle managers and builds the culture from the ground up." To help readers implement service ideas, Baird provides a considerable number of ideas, examples, techniques and tips. She offers a practical, step-by-step process for creating customer service excellence at all levels of a health care organization.

For more information on this book, call 1-888-378-2537.

Ageism Affecting Quality of Care for Canadian Seniors

Experts Develop New Program to Educate Healthcare Professionals on Unique Health Issues

Toronto. Ontario—July 24, 2000
The Canadian Working Group on Seniors' Health Issues today announced the launch of MATURE (Multidisciplinary Approach To Unequalled Results in the Elderly), the first in a series of revolutionary new programs to help overcome the prevalence of agism in Canada. The program, targeted to healthcare professionals across Canada, will help to ensure a comprehensive assessment of all elderly people, not just those believed to be frail or at high risk for significant long-term illness or death.

"The number of elderly persons in the developed nations is growing at an ever increasing rate," explained Dr. William Dalziel, President of the Canadian Geriatrics Society and Co-chair of The Canadian Working Group on Seniors' Health Issues. "There is a need for the medical professional to focus not only on the illnesses that are affecting seniors, but to recognize that many seniors can easily lead healthy lives well into their senior years. This program marks an important step in providing solutions to the challenges faced by healthcare professionals, patients and families in achieving effective health management for seniors."

The MATURE program was launched following the conclusion of the second annual meeting of the Working Group held in Toronto on July 7, 2000. The group has been formed to help address the urgent needs of Canadian senior by identifying issues and providing solutions to the ongoing and increasing challenges faced by the elderly.

Program Highlights

Although it has been well established that there are specific conditions that a physician should be aware of when assessing an elderly patient, these conditions are often overlooked. The program provides physicians and other healthcare professionals with education around preventive

approaches and screening tools for these common diseases, including depression, osteoporosis and dementia.

The first module, focusing on the "healthy senior" looks at:

1. Normal aging changes
2. Early warning signs and screening and assessment methods for common problems of the elderly including visual and hearing problems, depression, cognitive impairment, diabetes, hypertension, osteoporosis and influenza
3. Evidence-based primary and secondary health-promotion measures for the elderly

Beyond monitoring and screening the program also recognizes that physicians have an increasing role in helping their healthy elderly patients remain healthy" Counselling is also an important component of the overall assessment, including dietary recommendations and lifestyle modifications.

MATURE will be made available in the coming months to geriatricians across Canada through an educational grant from SmithKline Beecham Pharma.

"Aging can impact people's health in many different ways. Beyond the obvious disease states, their health is often affected by their economic situation, their role in society or their family, or their psychological state," explained Dr. Barbara Power, Chief of Geriatric Medicine, The Ottawa Hospital, University of Ottawa and Co-chair of The Canadian Working Group on Seniors' Health Issues. "We must begin to understand all of these issues."

In Canada, seniors already represent a significant proportion of the patients attended to by primary care physicians. This number is expected to increase significantly over the next decade. To ensure a good quality of life for Canadian seniors, physicians need to begin monitoring for early warning signs of a number of common problems. The majority of these conditions are treatable.

The Canadian Working Group on Seniors Health Issues

The Working Group includes representatives from the Canadian Geriatrics Society, The College of Family Physicians of Canada, Canada's Association for the Fifty-Plus, The Canadian Association on Gerontology, One Voice-The Canadian Seniors' Network, The Canadian Home Care Association, The Canadian Health Care Association, SmithKline Beecham Pharma, The Canadian Pharmacists' Association, Centre Hospitalier Université de Montréal-Pavillon St-Luc, The Canadian Home Care Association, Elizabeth Bruyère Hospital and The Canadian Gerontological Nursing Association. The Working Group is a result of a partnership between the Canadian Geriatrics Society and SmithKline Beecham Phama.

The Canadian Geriatrics Society is an organization of physicians specializing in care of the elderly. The CGS aims to advance the knowledge of physicians in the field of geriatrics through research, continuing medical education, support of undergraduate and postgraduate geriatric medicine programs and cooperation with other organizations concerned with seniors healthcare. SmithKline Beecham Phanna, and its shareholders are committed to the research and development of innovative medicines to satisfy Canadians' demand for exceptional healthcare. By ensuring patients' access to, and optimal utilization of its products, SmithKline Beecham will grow its business by delivering value to participants within the Canadian healthcare system. SB's therapeutic areas include psychiatric disorders, diabetes, Parkinson's disease, vaccines, cancer treatments, shingles, herpes, infectious diseases and arthritis.

For more information, please contact:

Genevieve Brown
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PharmaCom
(416) 586-0180

Catherine Jackson
SmithKline Beecham
Pharma
(905) 829.2030

Upcoming Events

Technology Aging

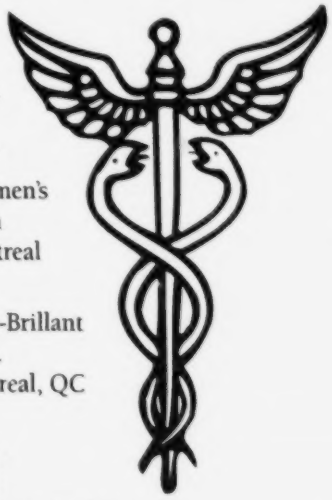
Quality of Life
Metro Toronto Convention Centre
Ontario, Canada
September 12–14, 2000

An international conference on technology and aging

Women's Health and Diversity

National Conference, April 26 to 28, 2001
Radisson Hotel, Longueuil, Montreal, Quebec

Registration until
February 1, 2001:
$125.00
After February 1st.
$150.00



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Aging: Debunking the Myths

Six Myths

Myth 1: Older people are all the same.
Reality: Older people are a very diverse group.

Myth 2: Men and women age the same way.
Reality: Women and men age differently.

Myth 3: Old dogs can't learn new tricks.
Reality: Older brains, when challenged with new activities, can continue to develop and learn until very late in life.

Myth 4: To be old means to be sick.
Reality: About three-quarters of seniors aged 65 to 74 and two-thirds of those aged 75 and older rate their health as good, very good or excellent.

Myth 5: Most older people need to live in institutions.
Reality: The vast majority of seniors live at home.

Myth 6: Older people have nothing to contribute to society.
Reality: Older people contribute a great deal to their families, communities, society and economies.

Be persistent without being impatient.
Dave Weinbaum, *The One-Line Philosopher*

Phone 'angels' reach out to isolated seniors

Leon Kuperberg believes in "invisible angels".

The 89-year-old lives in his own home and receives a phone call from his angel every week. And just who is this angel? She's a very real and special person who is one of the phone volunteers with Baycrest's Seniors Support Program.

The program has been operating for three years and helps more than 250 seniors in the Toronto area, many of whom are frail and living alone. Some are on the waiting list for long-term care, others may be recently widowed or struggling to look after a sick spouse.

Calling up a senior to say, "Hello, how are you today", is a simple gesture that makes them feel valued and cared about, says social worker Lesley Patterson, who coordinates the program. In some cases, it can be a lifeline for a senior who is unable to get out much and feels isolated. The phone volunteer is backed-up professionally by an in-house social worker and registered nurse.

Leon has been looking after Rachel, his wife of 62 years, since she had a series of strokes. Every Tuesday morning, he looks forward to a call from his phone angel Freda Slotnick.

"It is a full-time job caring for my wife," says Leon. "I'm very thankful when people call to ask how I am doing. It's just a simple phone call, but it means so much to me."

The Seniors Support Program needs more "invisible angels" for a few hours a week, either in the morning or afternoon.

For more information on this volunteer opportunity, please call (416) 785-2500, ext. 2250.

Source: *Volunteers: The Heart of Baycrest*

Coping With Stress— Coping Styles

By Gordon Hurler, Ph.D., Psychologist

You can find many books on stress and coping in the self-help or health sections of bookstores and libraries. Each book has its own advice on how to best handle stress. Although there are many different techniques that can be used to cope with stress, most can be grouped into three main categories:

1. Task-oriented,
2. Distraction-oriented and
3. Emotional-oriented.

The techniques in each of these categories have their advantages and disadvantages. Some work better with some types of stressors than others. As well, people often prefer or are more comfortable using some types of techniques than others.

Task-oriented techniques focus on doing something to change yourself, the stressor or the situation so that it is no longer stressful. Examples include reading about the problem, talking to an expert about the problem, reorganizing your schedule so that you can take care of the stressor, or learning a new skill to help you deal with the problem better.

Using organization and planning is also useful with problems that have deadlines, such as preparing your income tax return. Task-oriented techniques tend to be less helpful in coping with situations where you have little control or where you are simply waiting for time to pass (for example, worrying about your family travelling the highway during a bad storm).

For situations where lack of control or time is an issue, distraction-oriented techniques can be helpful. The purpose of distraction-oriented techniques are to help you to get your mind off the situation and allow you to relax, even if only for a brief period of time. Watching television, writing letters, surfing the Internet, and reading are all examples of distraction-oriented techniques.

Physical exercise or physical activities such as gardening, woodworking or doing housework may not only distract you, but can also be useful in putting the excess energy that comes with too much stress to a good cause. Distraction-oriented techniques should be avoided when a task-oriented approach would help get rid of or lessen the stressor. For example, if you feel stressed because you have not completed some job that needs to be done then you would probably be better off actually working on the job instead of distracting yourself from thinking about it!

Emotional-oriented techniques focus on addressing feelings and can be helpful in just about any situation. Seeking out companionship, talking with family and friends, or addressing spiritual needs are all emotional-oriented approaches.

For most people, talking out a problem, "getting it off my chest", can be very helpful. Talking with others lessens the burden. As well as getting support from others, occasionally you can get information or ideas that will actually help you deal successfully with the problem. If a family member or friend are not available or are not enough, then you might want to seek out some help (psychologist, social worker, family doctor, priest, minister or rabbi, etc.)

When choosing a technique to deal with a stressor, first check your own personal style—are you task, emotional or distraction oriented? Try to pick an approach that best fits your style. But also check that the technique you choose is the best not only for the moment, but for the long run as well. Don't use distraction when a task-oriented response is called for!

Source: *From the Heart*
ICONS Project Participants Newsletter
Volume 3, Number 1
March, 2000

Total-body Scan Clinic in Vancouver

A privately-owned Position Emission Topography (PET) clinic has opened on the UBC campus in Vancouver. It offers people access to a sophisticated total-body to detect cancers and other problems that may not be signaled by other diagnostic technology. Defending the $2,500 pricetag for a PET scan, clinic owner Denis Tusar told the *Vancouver Sun*, "People pay this amount of money to have LASIK eye surgery and that's far from being a matter of life and death."

According to the *Sun*, the clinic was set up after the B.C. government turned down a request by the Cancer Agency and Vancouver Hospital to set up a publicly-funded PET scan program.

Source: *Health Edition*, Vol 4, No.44

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Gene therapy: medical breakthroughs

by Leona Adamo Maxwell

Gene therapy is a phrase that has been the subject of many reports and much interest in the 90s. The concept is one that can inspire great hope, yet provoke fear. With the prospect of gene therapy as a cure, researchers and sufferers alike are hunting for what this can mean for illnesses as diverse as cancer, AIDS, arthritis, cystic fibrosis, musculoskeletal disorders, cardiovascular diseases, liver diseases, and inheritable diseases such as Gaucher disease, infectious diseases and more. The possibilities seem unlimited; the concept seems stolen from a science fiction novel.

For Pennsylvanians, there is much to be excited about because of the extensive research that is going on in the state's hospitals and universities, especially the Institute for Human Gene Therapy at the University of Pennsylvania Medical Center in Philadelphia, the Pittsburgh Genetics Institute at the University of Pittsburgh Medical Center and the Jake Gittlen Cancer Institute at Penn State College of Medicine at the Milton S. Hershey Medical Center.

Broadly defined, gene therapy is the use of genetic engineering to enhance a damaged cell or tissue, thus restoring its healthy function. In the case of cystic fibrosis, for example, an affected individual is born with a mutated gene that causes the disease. Gene therapy, then, strives to introduce a correct copy of the gene for cystic fibrosis into the person's body, thereby helping the body to recode its genetic malfunction.

When a potential therapy is identified, the clinical trials begin. Any research being done at this time is in the preliminary stages, or in Phase I clinical trials. A Phase I clinical trial, according to Dr. Nelson Wivel, deputy director of the Institute for Human Gene Therapy at University of Pennsylvania Medical Center, is performed to establish that the therapy under investigation is safe and can be considered for the next stage of determination, on its road to being declared a cure. As Wivel notes, "if something therapeutic happens, that's good," but the trials are not meant to declare a cure; rather to determine safety for continued study.

But that's still exciting. Currently, Wivel notes that since the first gene-related trials in September 1990, there has been a steady increase in clinical trials, and over 200,000 patients have been involved. "Eighty per cent of the trials focus on cancer because that is a disease for which we are all at risk and which primarily affects people as they get older."

In December 1996, researchers at Penn State's College of Medicine at Hershey Medical Centre reported the discovery of a "new gene that suppresses the metastasis, or spread, of melanoma, the often fatal skin cancer." Dan R. Welch, Ph.D., assistant professor of pathology at the College of Medicine's Jake Gittlen Cancer Institute, and Jeong-Hyung Lee, Ph.D., a postdoctoral fellow from Korea, isolated a gene, called KiSS-1, from the cells of malignant melanomas in humans. Welch explains that it has been tested on rats and is determined to be between 80 percent and 90 percent effective in inhibiting the spread of melanoma.

What does this mean to those of us who are waiting to see when the gene therapy for melanoma starts? Welch says that they are hoping by year's end to have materials necessary to begin testing on patients. "Research is going on around the world. We are working with the best people, but it also is a matter of luck."

Does that mean there will be a cure soon? "We've come a long way, but..." there is still more research and then the clinical trials. He notes with this particular research it's important to be appropriately encouraged, but not misled.

Cancer research and gene therapy is also a very important part of the picture at the University of Pennsylvania Medical Center. Wivel explains that much of the research centers around the "Holy Grail" of gene therapy, which is the "stem cell." The stem cell is the "godfather of all cells that reside in the bone marrow. They are the cells that give rise to all the different kinds of blood cells—red, white, platelets, lymphocytes."When cancer research is mentioned, stem cell research is

generally a part of the discussion, because of its importance to all the other cells. Most research regarding stem cells involves taking stem cells from the bone marrow of a patient and treating the stem cells with whatever gene therapy is being researched for that particular cancer. The objective is to make that population of blood cells resistant to whatever is attacking them. The cells are then reintroduced into the body through ferrying retroviruses which, depending on the cancer, bring the healthy blood cells to where they can fight the disease.

Currently, at the University of Pennsylvania Medical Center, Phase I trials are being performed in areas as diverse as brain tumors called malignant gliomas, for which there is very little to offer patients at this time in the way of standard treatment; and mesothelioma, a cancer related to exposure to asbestos.

All research being done is aimed toward clinical trials. In order for a cure to be identified, humans eventually have to come into the picture as part of the research. When they do, they are introduced to the concept by genetic counsellors. The goals of the counselors are to provide support and education for those patients for whom a clinical trial is a choice.

Erin Rice, a genetic counselor for patients with Gaucher disease, works at the Pittsburgh Genetic Institute at the University of Pittsburgh Medical Center. She explains that doctors here, under the direction of John Barranger, Ph.D., are involved in many programs, one of which is the Gaucher clinical trial. Gaucher disease is an inherited disease. It causes enlarged organs, bone deterioration with multiple fractures and progressive nervous-system degeneration.

Rice's job is to identify patients who might benefit from the gene therapy trial and then counsel them as they go into the therapy. Currently, medication is available for the disease, but the treatments are very expensive, so an approach that could combine the gene therapy with reduced doses of medication would be a benefit to sufferers. Throughout the process, Rice educates, reviews and supports those patients.

In this particular trial, the University of Pittsburgh has been approved by the FDA for four transplants (all trials go through a lengthy approval process that includes, finally, FDA approval for the trial).

Irene Marshall is a patient at the University of Pittsburgh Medical Center who agreed to be a part of the trial. She has received four transplants and has now been approved to reduce her medical treatments by 50 percent. With gene therapy, there is often a fear factor born of movies like The Island of Dr. Moreau or Frankenstein, which depict the results of playing around with what nature intended. Few people are comfortable with someone tampering with their DNA, so deciding to be part of a clinical trial involving genes is a courageous decision. Marshall is a nurse who weighed her options and decided to be part of the clinical trial for Gaucher disease. As a nurse, I knew of the complications," says Marshall. But she felt and still does feel "real confident about it (gene therapy).

"This is the time to be living," she says. "Just when my problems started to become really serious, there is the new treatment. ..I wasn't afraid, because it has to go through so many channels to get to a trial. I knew it would be safe."

Tests are performed on somatic cells. Wivel explains that somatic cells are those cells in the body that are not part of the germ line, which is the reproductive line. Therefore, therapy done on somatic cells can only affect the patient; it cannot be passed on to the next generation.

Of course, that is good news and bad news. For those who have hereditary diseases, it would be comforting to know that they could be treated before having children to prevent them from getting it. But there is no approved study for germ line gene therapy or enhancement therapy for improving looks, intelligence or changing the sex of a child. According the Wivel, the medical community considers enhancement therapy unethical.

The good news in Pennsylvania—by the year 2000 some residents could be cured through gene therapy. Whatever the connection, you or your family is sure to benefit from the research being done in your own back yard.

Did you know?

That you can receive a tax credit for travel expenses incurred in obtaining medical services that meet certain criteria:

- travel distance of at least 40 km
- substantially equivalent medical services are unavailable within the patient's locality
- the patient takes a reasonably direct travel route
- it is reasonable, in the circumstances, for the patient to travel to that place for the medical service
- the travel expenses of a companion/driver may be covered if a doctor certifies that the patient would "be incapable of travelling without an attendant"

What do you need to keep track of these costs?

You have the option of choosing a detailed or simplified method to calculate certain travel expenses:

- **Simplified Method**—for meal expenses (only available for trips 80 km or more), you can claim a flat rate of $11 per meal to a maximum of $33 per day, per person, without receipts; lodging may also be covered if over 80 km (check requirements); for vehicle expenses, you keep track of the number of kilometres used for 40+ km medical travel over during the 12-month period that you choose & multiply by 36.4 for NS residents
- **Detailed Method**—for meal expenses, you collect your actual receipts; for vehicle expenses, you keep receipts & records for any vehicle expenses for medical travel over 40 km over the 12-month period, including operating & ownership expenses (depreciation, provincial tax, finance charges) & operating expenses (fuel, oil, tires, licence fees, insurance, maintenance, repairs) as well as the number of km actually travelled over 40+ km

Medical services: May include the services of nurse, medical practitioner, dentist, pharmacist, osteopath, chiropractor, naturopath, therapeutist/ therapist, physiotherapist, chiropodist/ podiatrist, psychoanalyst (if member of CIP), psychologist, qualified speech-language pathologist/ audiologist, qualified occupational therapist, acupuncturist, dietician, dental hygienist

For more information call 1-800-959-8281

Centre on Aging Data Sets

The Centre on Aging has a variety of data sets that are available to students and researchers. In particular, the Centre has data sets that have been constructed from research carried out by Centre researchers. The following list is a sample of the code books constructed from Centre data sets. If you would like more information about them, please contact our Research Coordinator Gordon Behie at gbehie@uvic.ca or 250.721.6368.

Caregivers to Adults & Children in British Columbia, by N.L. Chappell, M.J. Penning, 1994. Research supported by the Seniors Independence Program (SIP), Health Canada through the Caregivers' Association of BC and the Respite Care Committee, Continuing Care Division, BC Ministry of Health.

Study of Seniors and Their Caregivers, Interview Schedule, by N.L. Chappell, V. Kuehne, 1995.

Baseline Study of Seniors in the Capital Regional District Project, Spring 1995. Research supported by the David and Dorothy Lam Endowment at the University of Victoria Foundation.

Independence Among Frail Seniors: The Role of Formal Care Services, Informal Caregivers and Self-Care, by M.J. Penning, N.L. Chappell, P.H. Stephenson, H.A. Tuokko, L. Rosenblood, 1997 (Second Questionnaire). Research supported by the National Health Research and Development Program, Health Canada. Non-Service Users and CRD Home Support Service Users Codebook.

Source: *The Bulletin*, The Centre on Aging
University of Victoria
Fall 2000 Volume 8 Number 3

Diabetes Research News

This summer, the Canadian Diabetes Association announced the National awarding of $5 million in research funding. This money will be used to fund promising research initiatives across Canada, under the categories of personnel awards, operating grants, and applied research.

In Nova Scotia, researchers Dr. Hyo-Sung Ro and Dr. Ehud Ur, both from Dalhousie University, were awarded operating grants from the Canadian Diabetes Association. Dr. Ro's research will continue to study how certain molecules in the body signal for new fat cells to be made, allowing us to understand ways to block new fat cells from developing, and to prevent fat from collecting in these cells. This may lead to new ways to control obesity, and subsequently reduce the risk of type II diabetes.

Dr. Ur and his colleagues will continue to conduct studies on leptin, a protein produced by fat cells, which acts on the brain in order to reduce food intake and to increase energy expenditure. Until recently, leptin was thought to be produced only by fat cells, but Dr. Ur's team has now shown that leptin is also made in the part of the brain which controls appetite and weight. Further findings may help us better understand the causes of obesity, and hence develop new treatments for it and its consequences, one of which is diabetes.

A portion of Canadian Diabetes Association research dollars continues to be specifically earmarked for islet cell research. Internationally-recognized research at the University of Alberta, funded in part by the Association, and led by Dr. James Shapiro, confirmed that eight patients with type I diabetes had been able to stop taking insulin after undergoing islet cell transplantation. The researchers had successfully transplanted insulin-producing islet cells from donated pancreases into the livers of the patients. To date, the research has allowed these patients to produce their own insulin for over a year , making insulin injections unnecessary. Islet cells are located in the pancreas, and a small portion of the pancreas is made up of cells that secrete hormones, such as insulin.

These insulin-producing cells are called the Islets of Langerhans. The potential for islet cell research is that one day the reversal of diabetes in humans may, in fact, be possible, and it also suggests the need to explore alternative sources of insulin-producing tissues, as donated pancreas organs are in short supply. Drs. Edmond Ryan, Gregory Korbutt, and Jonathan Lakey, members of the Edmonton research team, were in Halifax this month to attend the Association's Professional Conference.

Finally, it was recently announced that in Calgary, a group of researchers, also funded in part by the Canadian Diabetes Association, unveiled a significant step towards understanding the development of type I diabetes. The Study examines the way in which inflammation of the pancreas in type I diabetes progresses to overt disease, and the role certain white blood cells play in this process. The research outlines how the body's white blood cells cause inflammation, and eventual destruction, of islet cells. The pancreatic cells recognize protein markers on the surface of the islet cells, and this allows the white blood cells to bind and damage the islet cells. By treating mice predisposed to diabetes with protein, the researchers have discovered that they can halt the destruction of insulin-producing insulin-producing cells, thereby preventing mice from developing diabetes.

The Calgary Study, led by Dr. Pere Santamaria. suggests a strategy to block the onset of type 1 diabetes in at-risk individuals. Dr. Santamaria received the Canadian Diabetes Association's Great West Life & London Life Young Scientist Award at the October Conference.

Source: *Scotia Banter*
Canadian Diabetes Association
Fall 2000

Community Health Promotion Network Atlantic

We Believe health promotion is a dynamic and developmental process that improves our well-being in all its dimensions: economic, social, cultural, educational, physical, spiritual, and emotional. Communities Benefit from sharing and developing their knowledge, experience, resources and skills in order to organize and take action.

Health promotion requires collaboration between and among government, voluntary organizations, individuals, community groups and professionals from diverse fields at all levels.

Population Health helps us to think about health in a holistic way. We're aware that many factors called determinants influence health: healthy child development, income and social status, gender, social support networks, education, genetics, employment and working conditions, health services, physical environment, personal health practices and coping skills, culture.

Benefits of Being a Member

Information

- newsletter Health Promotion Atlantic
- access to resources and people from across the Atlantic region
- news about events, issues, and funding possibilities

Support

- a chance to learn (through our web-site, the Sharinghouse, and our online discussions) from the experiences of the groups and individuals in all the Atlantic provinces
- the opportunity to form partnerships and working groups

Networking

- an effective means (on-line. in print and word-of-mouth) to get your message out all across the Atlantic provinces
- discussion of issues and strategies from many points of view

Fees include: individuals $20.00; community organizations $30.00; Provincial not-for-profit $50.00; independent consultant $75.00.

In Nova Scotia contact us through: Phyllis Price, 18 The Lane, Broad Cove, R.R. #2, Mill Village, NS B0J 2H0; tel: 902-677-2794; fax: 902-688-2591; e-mail: coveside@fox.nstn.ca

"I want to go home"

"I want to go home!" The hurt cuts deeply when your resident's parent begs to leave his or her continuing care facility and go home. What can you do? The following are some suggestions in tackling the "I want to go home" syndrome:

1. Bring home to them.
2. Encourage them to talk about the old days.
3. Tape their stories.
4. Help the person to go home in their own mind.
5. Reinforce the positive and ignore the negative.
6. Don't let the words "I want to go home" wave a red flag in your face.
7. Listen to complaints.
8. Keep a sense of humour.
9. Practice mental imagery.

"I want to go home" is not the real issue. Reassurance is, and you can provide that. One underlying premise is always to speak the truth. Don't tell the parent you will take him or her home if you do not fully intend to.

Readapted. Source: Evelyn B. Kelly, PhD, "*How to counter the 'I want to go home' Syndrome*, *The Later Years*, a service of The Brown University Long-Term Care Quality Advisol; Mainisses Communications Group, Inc.

Olive Oil

Olive oil is a heart-friendly, mono-unsaturated fat. But extra-virgin olive oil is more heart-protective than refined virgin or "light" varieties.

Extra-virgin oils undergo less processing and retain more of their beneficial compounds than refined olive oils.

These compounds help prevent "bad" LDL cholesterol from oxidizing, a process that can cause plaque to build up in the arteries.

Source: *Journal of Nutrition*, Vol. 129, No. 12

Nova Scotia Seniors for Literacy Project

The Nova Scotia Seniors for Literacy Project is a twelve month province-wide research effort that will document the literacy and upgrading needs of seniors 50 years of age and older.

The 1994 International Adult Literacy Survey (IALS) showed that seniors in Nova Scotia have low literacy levels across the three literacy domains: prose literacy, document literacy and quantitative literacy. In addition, we know that 34% of seniors 65 years of age and older, have less than a grade 9 education. While these statistics provide general insight into the literacy levels among seniors in Nova Scotia, they do not provide a clear definition of their specific upgrading needs, nor do they clearly address the rural versus urban dynamics relative to seniors' literacy issues. Moreover, they are not community specific and do not document the unique needs of those senior citizens who are isolated in their homes.

The goal of the Nova Scotia Seniors for Literacy Project is to prepare a strategic plan that will guide the development of programs, services and projects to address the literacy and upgrading needs of seniors in Nova Scotia. Data that will inform this issue and that will help to identify possible solutions will be collected via four means:

1. Twenty-four focus groups will be organized in rural and urban communities across the province.
2. Front line staff with the Victorian Order of Nurses (VON) and Home Care Nova Scotia will administer a brief questionnaire to a sample of isolated seniors in their care.
3. VON and Home Care Nova Scotia personnel from across the province who support seniors, will be asked for their insight on the literacy needs of their clients. Their suggestions for enhanced services to seniors with literacy needs will be documented and presented by their managers at an information meeting in Halifax.
4. A survey on the literacy needs of seniors will be administered to a broadly based sample of community-based upgrading programs in Nova Scotia.

A final report and strategic plan for addressing seniors' literacy needs through local community projects and/or through provincial initiatives will be prepared and distributed widely.

For more information on this project please contact: Anne Porter, Project Coordinator
Senior Citizens' Secretariat, 4th Floor,
Dennis Building 1740 Granville Street,
P.O. Box 2065 Halifax, Nova Scotia B3J 2Z1

Phone: (902) 424-4779/424-4737
Fax: (902) 424-0561 Email: porteram@gov.ns.ca
Toll-free: 1-800-670-0065.

Live to learn and learn to live.
Portuguese Proverb

"Don't Ever Leave Me"

A CD release celebration for singer John O'Halloran was held November 20, 2000 at Northwood Terrace. John was accompanied by Earl Fralick and the emcee was Tony Beech.

The CD is a collection of songs by Jerome Kern and will be available in local stores and on the Internet at www.supproductions.com. The price of the CD is $20.00.

John O'Halloran is a seasoned performer and began singing at age 4, and throughout his life has performed in stage/theater, lounges and supper clubs, choir and chorales, radio and television, series TV including Black Harbour and has also performed in five movies.

John has a superb baritone/baritone voice, rich and easy to listen to. It was a pleasure to be with John, family and friends during his CD debut at aged 75. John is a prime example of living life to the fullest. His gift of music is being shared by many and will continue to leave a legacy of his talents.

For further information, please contact Connie Eaton at (902) 423-6971.

Submitted by Valerie White

Women & Sleep Apnea

Sleep apnea—a condition where people stop breathing for brief periods while they sleep—has been linked to heart disease risk in previous research.

New research suggest that decreased hormone levels may be partly responsible for sleep apnea's increased incidence and severity in post-menopausal women.

In a sleep laboratory study, 47% of post-menopausal women had sleep apnea—compared to only 21% of a pre-menopausal group.

Researchers recommend a closer look at hormone therapy as a possible treatment for sleep apnea in post-menopausal women.

Source: 96th International Conference of the American Thoracic Society

Understanding

"When you plant lettuce, if it does not grow well, you don't blame the lettuce.

You look for reasons it is not doing well. It may need fertilizer, or more water, or less sun. You never blame the lettuce.

Yet if we have problems with our friends or our family, we blame the other person. But if we know how to take care of them, they will grow well—like the lettuce.

Blaming has no positive effect at all, nor does trying to persuade using reason and arguments.

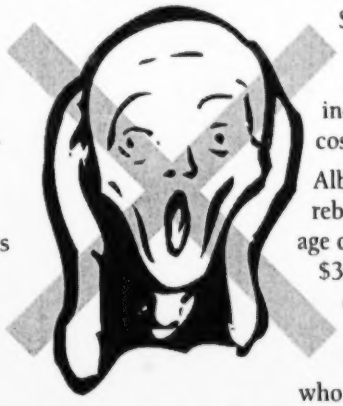
That is is my experience.

If you understand, and you show that you understand, you can love, and the situation will change."

Thich Nhat Hahn, *Peace Is Every Step*

De-stress Your Holidays

- Make a list of all the things you and your family like—and dislike—about the holidays. Build your own traditions around the highest-scoring "likes."
- Take care of your body. Get at least 30 minutes of brisk exercise every day. Stop eating when you're full—but don't skip meals, either. Be sure to allow yourself a few holiday treats.
- Limit alcoholic drinks to one or two a day. Don't drink and drive, and fasten your seat belt.
- Get plenty of sleep.
- Take care of your spirit. Give yourself at least a couple of days to do what you want to do.
- Realize that you are not solely responsible for making the holidays special for everyone else.



- Don't accept every invitation you receive.
- If this is your first holiday after a divorce, death or end of a relationship, remove yourself from reminders of the past. Do something you've never done before.
- Give your time and friendship rather than presents. Volunteer at a soup kitchen. Drive a housebound friend or neighbor around the neighborhood to see the holiday decorations.
- Keep your sense of humor, and count your blessings.

Source: *Looking Forward*
The Hope Heart Institute
Vol. 13, No. 6 - Early winter 2000

High Fuel Costs

Canadians are facing high increases in the cost of home heating fuels—whether heating with oil, electricity or natural gas. Because of the forecasted cold winter there will be an increased usage of home heating fuels imposing a terrible burden for people on low-incomes or fixed incomes, such as seniors.

Seniors' organizations are urging the provincial government to provide rebates for seniors and other low-income families to offset the increased costs of home heating fuels.

Alberta has developed two non-taxable rebate programs for all Albertans over the age of 16 years. The first program provides $300 per person to offset the increased cost of home and automobile fuels. The second is an electricity rebate of $20 per month on the bill of those who pay the electrical bill, starting in January 2001 and in operation for the entire year. It is recommended the government consider these rebate programs for Nova Scotians on low-incomes.

Redvers Cainey
Canada's Association for the Fifty-Plus
(CARP)

Age is a matter of feelings, not of years.
George William Curtis (1824–1892), Writer

Remaining Healthy: It's Never Too Late!

Old age is not a disease. Although we develop more health problems as we get older, we don't necessarily have to resign ourselves to years of sickness. Modern health care includes taking personal responsibility for our health no matter what our age.

It is never too late to try to maintain good health. Remember, if you are 65, you can expect to live 15 more years; if you are 75, you can expect 10 more years; and at 85, expect an average of six more years. Most of us want to add as much "life" as possible to these years.

There are several simple, straight-forward measures that seniors can take to help prevent illness and maintain health. The following are just six of these simple steps.

Have a family doctor

Preventive medicine is an important part of family practice. Your family doctor is your main link with the constantly changing health-care system. Find a family doctor with whom you can discuss your health maintenance plans. This is the person you can turn to if your need medical advice and support for your plans. Your doctor will respect you for taking steps to remain healthy and will help you toward your goal.

Exercise

If you keep physically active, you can slow certain changes that occur with aging. Older people who have always exercised are proof of this. Exercise helps maintain muscle strength, oxygen use and many body functions. Even after years of inactivity and the loss of conditioning that results, careful exercise may improve muscle weakness and increase the range of joint movement. Remember you can even exercise in a wheelchair!

Balance, strength and endurance can all be improved in the elderly. Obviously, older people planning to exercise should consult their family doctors to determine suitable and safe exercise programs.

A combination of endurance exercise and strength training is often recommended. Walking and cycling are the most common examples of endurance exercise. Strength training involves contracting groups of muscles against resistance.

This is not restricted to the young. It is not unusual these days to see seniors involved in weight training and enjoying it.

Regular exercise promotes an improved self-image and a sense of well-being in the elderly, as well as in younger people. It can help combat depression. Exercising with others is a way to deal with loneliness. Carefully planned exercise is becoming part of the management of a range of medical problems of older people. These include diabetes, arthritis, osteoporosis, constipation, Parkinson's Disease, obesity, and heart disease and its risk factors.

Stop Smoking

Studies show that even older people benefit from an end to smoking. Elderly smokers who stopped as recently as two years earlier have reduced their risk of death compared with those the same age who continue to smoke. The risk of heart attacks is reduced within a year after stopping smoking.

Stopping the tobacco habit also slows the rate of decline of lung functioning and may help slow the development of osteoporosis. These are just some of the good reasons for a person of any age to stop smoking.

Have your blood pressure checked

Hypertension (high blood pressure) is common in the elderly. It is a serious problem. Blood pressure is recorded as an upper figure (systolic) over a lower figure (diastolic). Until recently the emphasis was mainly on the risk of an elevated diastolic pressure. However, studies now show that a systolic pressure above 160 mmHg puts an older person at increased risk for heart attack and stroke.

Treatment of high blood pressure can prolong your life because your risk of heart attack and stroke is reduced. Although non-drug treatment such as exercise can be mildly effective, medication is usually indicated when high blood pressure is confirmed. Doctors have a choice of medications and will select the drug most suitable for you.

There is an important point to remember in relation to your blood pressure. Be aware of dizziness when you stand up from a lying or sitting position, especially if you are taking medication for high blood pressure. Sometimes your blood pressure will drop quickly when you stand, which can cause dizziness and possibly a fall.

It's a good idea for your blood pressure to be checked in both lying and standing positions. A significant drop in blood pressure on standing is called postural hypotension and may affect how your doctor treats your high blood pressure.

Have your hearing and eyes checked

Hearing loss is common as we age. It occurs in 30 per cent of those older than 65 and in 50 per cent of those older that 85. The good news is that it is usually treatable. In the most common type of hearing loss, there is difficulty hearing high pitched sounds, especially when there is background noise.

If you are having hearing problems, have your hearing checked. Hearing tests are simple and hearing aids usually help the hearing loss. Remember too, removing wax from your ears often dramatically improves hearing so you may not need a hearing aid.

Deafness causes elderly people to isolate themselves socially and contributes to depression. Why suffer from the results of hearing loss when you don't have to?

Have your eyes checked. Increased pressure in the eye, glaucoma, is the most common cause of blindness in Canada. Moreover, it is preventable if discovered before any symptoms occur! Older people have a higher risk of this serious but treatable condition.

Get a flu shot

Everyone over age 65 is in the at-risk population that should receive influenza vaccine (a flu shot) yearly. The only ones in this group who should not receive the vaccine are those who have serious allergic reactions when the eat eggs.

Influenza vaccine can prevent flu and the complications of pneumonia and death. At particularly high risk of these problems are older people with chronic heart, lung and kidney diseases, diabetes and diseases or drugs that affect their immune systems.

The vaccine is effective, safe and inexpensive. Special flu shot clinics organized for the elderly often make it easier to receive the vaccine.

Ask a senior

Treat yourself well. Ask yourself three questions and then get busy.

1. Are you interested in keeping healthy?
2. What better investment can you make?
3. Why not start now?

Written by: Murray Nixon, MD, CCFP, FCFP,
A family doctor practicing in Halifax, Nova Scotia

Everything has beauty, but not everyone sees it.
Confucius

G.R.A.N.D.

Grandparents, Requesting, Access, and Dignity

During the past year the Secretariat has met with a group of grandparents who have had the experience of being denied access to grandchildren due to the divorce of their adult children and the emotional upheaval of these changing relationships. These grandparents had close relationships with their grandchildren before being denied access. Sharing holidays, serving as babysitters and actually having daily or weekly contact came to an abrupt end. We know that grandparents are very often a stabilizing factor in grandchildrens lives and offer unconditional love and a safe refuge when parental relationships are strained. The two-way benefits of learning together and sharing hobbies, past experiences and new challenges are quickly taken away.

Through the assistance of mediation, through friends, ministers and mental health professionals many relationships have been restored to the benefit of all concerned. Too often in the past legal costs have been high and the legal process has polarized attitudes, instead of encouraging consensus. Because of the loss of close relationships, grandparents in this situation need the support from others who can offer hope and share the steps others have taken to restore the grandparent grandchild relationships.

In a time when challenges and change are affecting families it's a wonderful time to strengthen family relationships between older and younger persons. The age gap can be overcome, especially around values and cultures.

Interwoven in the aims of G.R.A.N.D. is the belief that grandparents have a Right to grandchildren and grandchildren have a Right to know and have relationships with grandparents.

If you are interested in supporting this organization please attend the inaugural meeting January 23, 2001 at the Dartmouth Senior Kiwanis Multi-Service Centre, 45 Octerloney Street, Dartmouth at 1:00 p.m.

For further information please call: 462-3764 or 865-5172 or contact: The Senior Citizens' Secretariat at 424-0065 or toll free at 1-800-670-0065

Aims of G.R.A.N.D. Society

- serve as a support system
- support the best interests of the child
- encourage mediation
- create public education and awareness
- encourage family life education
- promote changes in legislation to allow specific recognition of grandparents

This is a non-profit organization formed to promote grandparents and grandchildren working together for a brighter future.

Oblectives

A) The group shall provide a forum giving grandparents a place to air their concerns either personal problems or where someone has communicated with a member by phone, a letter of support and information will be sent.

B) Where possible to provide guest speakers.

C) We have the right to expel and/or refuse admission or membership at any time to any person whose purpose seems to be to interrupt our speakers, executive persons, or members.

D) Or is found to be soliciting members for financial gain.

E) Or is known to subject any member to physical/mental/racial or sexual harassment.

F) **Confidentiality:** The privacy of the members and their personal situations must be respected by all members at all times.

Headache Pain. How To Make It Go Away.

	Migraine	Cluster	Tension
How it feels	Pulsating or throbbing	Excruciating, sharp, throbbing and/or steady.	Dull, persistent and/or pressing.
Other symptoms	Visual aura, nausea, vomiting, and/or light and noise sensitivity.	Sweating, flushing, stuffy nose and/or red, watery eyes.	Mild intolerance to light and noise and/or loss of appetite.
Location	Usually just one side of the head.	Behind or around one eye.	In a band around the head.
Duration/ frequency	2 to 72 hours from 8 or more episodes a month to l or 2 a year.	15 to 90 minutes 1 to 8 attacks per day for 3 to 16 weeks, with 1 to 2 episodes per year.	30 minutes to 7 days from 3 to 4 episodes a week to l or 2 a year.
When they occur	Varies from person to person.	Often during sleep usually at the same time each day.	Under stress.
Family history	Yes	No	Yes
Gender	Women more often than men.	Men more often than women.	Women more often than men.
Prevention/ treatment	**Prevention:** Avoid triggers (certain foods, stress, etc.); biofeedback; relaxation therapies, preventive medications (e.g., antidepressants). **Treatment:** Over-the-counter painkillers (e.g., Extra-strength Excedrin) and prescription medications (e.g., triptans).	**Prevention:** Avoid alcohol, smoking and drugs that dilate blood vessels (e.g. nitroglycerin, histamines). **Treatment:** Prescription drugs (e.g., ergotamine, lidocaine); oxygen for acute attacks.	**Prevention:** Biofeedback or relaxation therapies. **Treatment:** Over-the-counter painkillers.

Sources: Adapted from American Family Physician, Vol. 51, No.6; National Headache Foundation.